State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

JAMES E. MCGREEVEY
Governor

GWENDOLYN L. HARRIS
Commissioner

KATHRYN A. PLANT
Acting Director

MEDICAID COMMUNICATION NO. 02-13 **DATE:** May 8, 2002

TO: County Welfare Directors
New Jersey Care...Special Medicaid Programs Liaisons
Statewide Eligibility Determination Agency

SUBJECT: NJ FamilyCare Conversion Pilot Program

As you are aware, the Division of Medical Assistance and Health Services (DMAHS) has implemented a pilot program for establishing Medicaid eligibility through the aged, blind or disabled segment of the New Jersey Care...Special Medicaid Programs for certain NJ FamilyCare eligible individuals, using medical data and/or claims collected by the HMOs and the PRO of New Jersey.

BACKGROUND

Historically, individuals who received medical services through the WFNJ General Assistance program and who appeared to have medical or behavioral problems were referred to the Social Security Administration (SSA) for a determination of disability and eligibility determination for SSI and related Medicaid benefits. Under current practice, in most cases, the Division will not conduct an independent disability review and defers to the SSA's disability determination.

Based upon our NJ FamilyCare experience with single adults, including the WFNJ/General Assistance population, it has become evident that many single adults receiving medical assistance, because of their critical medical needs, may qualify for Medicaid coverage as disabled individuals. Pursuing Medicaid eligibility for these NJ FamilyCare eligibles, where possible, provides more comprehensive medical services, in addition to providing federal reimbursement, particularly critical in the current fiscal climate.

Under the Pilot, the Division's Disability Review Team (DRT) is reviewing medical documentation that has been submitted for a small number of NJ FamilyCare cases to make a determination of mental or physical disability. These cases were selected from high utilization claim data or by referral from a participating HMO. The Division plans to use the project's outcome to determine if a change in policy to permit a concurrent disability review process is warranted.

Once a case has been approved by the DRT as meeting disability criteria, and therefore, categorically eligible, the DRT disposition and supporting medical information will be forwarded to your agency's New Jersey Care...Special Medicaid Programs liaison for a financial determination of Medicaid eligibility under the aged, blind or disabled segment.

DMAHS REVIEW

The Division will be selecting certain cases to forward to your agency. There are situations in which the individual may have already applied to the Social Security Administration for disability benefits, and a determination has been made, favorable or unfavorable. These cases will be reviewed further by DMAHS to assess whether a financial eligibility determination by your agency is warranted.

The Division will also be reviewing cases prior to a referral to your agency to identify cases that have already been found eligible for SSI or New Jersey Care coverage. Additionally, restricted aliens who are eligible under the NJ FamilyCare program may not qualify for Medicaid due to their immigration status. Accordingly, none of these cases will be referred to your agency.

ELIGIBILITY PROCESSING

Once a positive determination of disability is made by the DRT and a financial determination by your agency is warranted, the PA-8 form and supporting medical documentation used by the DRT to determine disability will be forwarded to your agency to establish a New Jersey Care...Special Medicaid Programs case record.

To facilitate eligibility processing, materials to be forwarded include the attached cover memorandum that provides basic case information and identification of the NJ FamilyCare supervising agency and contact person. Since NJ FamilyCare cases are supervised by one of three agencies, the county welfare agency, the municipal welfare office or the statewide eligibility determination agency, we are requesting that your New Jersey Care...Special Medicaid Programs liaison take the lead to obtain a copy of the most recent WFNJ/General Assistance or NJ FamilyCare application and any required case materials. In lieu of, or in addition to either of the above, information available as part of a current Food Stamp or other eligibility record may be used to determine Medicaid eligibility without obtaining more information from the individual (ex parte).

In determining eligibility for the aged, blind or disabled segment of the New Jersey Care program, there are additional eligibility criteria to take into consideration, i.e., in-kind support and maintenance and available resources, since these requirements do not apply to most segments of the NJ FamilyCare program. If the required information is not obtainable by an ex parte review of an existing application, it may be necessary for your staff to contact the individual directly to obtain this information.

ELIGIBILITY DISPOSITION

Once your staff have completed the Medicaid financial eligibility determination, the bottom section of the cover memorandum with the case disposition information requested should be completed and copies forwarded to the DMAHS Disability Review Team and to the NJ FamilyCare supervising agency contact liaison.

If **financially ineligible,** no formal notice to the beneficiary is required, but a case dismissal should be noted in the case record. If the individual is determined to be

If you have any questions concerning this pilot, please contact the DMAHS Disability Review Team at (609) 588-2934 or the Bureau of Eligibility Policy field staff assigned to your counties, at (609) 588-2556. I would like to take this opportunity to thank you and your staff for your continued efforts and cooperation is assuring maximum coverage for our mutual beneficiaries.

Sincerely,

Kathryn A. Plant

Kathryn A. Plant
Acting Director

KAP:S
Attachments (3)
c: Clifton R. Lacy, M.D., Commissioner
William Conroy, Deputy Commissioner
Department of Health and Senior Services

David Heins, Director
Division of Family Development

Charles Venti, Director
Division of Youth and Family Services

If **financially ineligible,** no formal notice to the beneficiary is required, but a case dismissal should be noted in the case record. If the individual is determined to be **financially eligible** for this segment, there are certain coordination activities that must take place in addition to the above disposition in order to assure that eligibility continues without interruption of coverage. The following provides general guidelines to your agency for processing eligible cases:

- The county board of social services is responsible to advise the beneficiary of his Medicaid eligibility, retroactive to the initial NJ FamilyCare eligibility date, no earlier than September 2000, and to advise of a change of coverage from NJ FamilyCare benefits to Medicaid coverage;

- Assign a new Medicaid identification number for the New Jersey Care cases and update the Medicaid Eligibility System with eligibility retroactive to the original NJ FamilyCare eligibility date. Coordination with the supervising agency is of critical importance to assure no interruption of coverage;

- For WFNJ/GA cases (PSC 761) supervised by your agency or the municipality, the county board of social services will accrete the New Jersey Care eligibility to the Medicaid Eligibility File and coordinate the information with the supervising agency. Those agencies using GAAS must be advised of the individual's Medicaid eligibility and instructed to change the household screen to "yes" for the response to "Are you receiving Medicaid?" in order that duplicate Medicaid cards are not issued. In an effort to not disrupt coverage, it is important to be aware of the monthly cutoff dates;

- For NJ FamilyCare cases identified with PSC 762 and 763, the termination of NJ FamilyCare eligibility and the addition of the New Jersey Care case must be coordinated with the supervising agency in a timely manner in order not to interrupt coverage. Again, it is of critical importance that coordination takes place prior to the monthly cutoff to assure continued coverage. **No NJ FamilyCare case should be terminated until transition to the new Medicaid number has occurred.**

- For purposes of redetermination, the date of the New Jersey Care eligibility determination will be used to define the redetermination date. For example, if you determine a case New Jersey Care eligible in April 2002, retroactive to September 2001, the redetermination date will be May 2003.

The attached procedures and above information are general guidelines for your staff to follow when processing these cases. While they may not address every nuance, we ask that your agencies decide how best to respond to the coordination issues internally and on a local level, per current practice. Since many of your agency staff have been directly involved in the NJ FamilyCare eligibility processing and are familiar with the coordination issues, we suggest that your NJ FamilyCare staff serve as resource staff to the New Jersey Care liaisons to assist in coordinating eligibility for these cases, if appropriate.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
DISABILITY REVIEW TEAM
NJ FamilyCare Conversion Pilot

DATE:

TO: New Jersey Care Liaison County Board of Social Services	FROM: Medical Consultant DMAHS Disability Review Team P.O. Box 712 Trenton, New Jersey 08625 (609) 588-2934 FAX: (609) 588-7343

RE:	**HSP#:**
SS#:	**PSC:**
Eligibility Date(s):	**SSI application Date:**
Supervising Agency:	**Liaison:**
Phone#:	**Fax#:**

The Division's Disability Review Team has determined that the above individual meets the disability criteria for the aged, blind or disabled segment of the New Jersey Care...Special Medicaid Programs. Enclosed you will find a completed DRS 3/PA-8 form and medical documentation to support this decision.

We are requesting that you conduct a financial eligibility determination for Medicaid eligibility under the New Jersey Care program for the individual, based upon the most recent WFNJ/General Assistance/NJ FamilyCare application. Please contact the above supervising agency liaison to obtain a copy of all relevant NJ FamilyCare case materials required for your eligibility determination.

Enclosures
C: Supervising NJ FamilyCare agency liaison

Once you have completed your evaluation of Medicaid eligibility for this individual, please complete the following section and forward a copy to the DRT Medical Consultant at the above address. If determined eligible, please accrete the individual's New Jersey Care eligibility to the Medicaid Eligibility File and coordinate as appropriate with the NJ FamilyCare supervising agency liaison.

CASE DISPOSITION

Eligible:_____	**Ineligible:**_____
Effective date:	Reason:
Medicaid #:	

Signature: _____ Date: _____

Ex Parte:

An ex parte determination of Medicaid eligibility is conducted without the involvement of the beneficiary. It is based upon, to the maximum extent possible, information contained in the individual's case record or other sources determined to be accurate. Sources may include Food Stamp and Work First New Jersey records, wage and payment information, or information from the SDX or ABIE systems.

In the event that an ex parte determination cannot be made because additional information is needed, reasonable steps may be taken, such as contacting the beneficiary.

Redetermination:

For purposes of this pilot program, the New Jersey Care redetermination date will be one year from the date of the ex parte review, or from the date of last financial review.

ELIGIBILITY FACTORS:

PSC 761

For purposes of New Jersey Care eligibility, the assumption can be made that a WFNJ/GA beneficiary meets the citizen and resource requirement for Medicaid. However, in-kind support and maintenance has to be reviewed and considered. Any health insurance coverage should be reported on a TPL-1 form.

PSC 762

Resources and in-kind support factors should be reviewed, since they are not considered in the NJ FamilyCare eligibility for this group, but are counted when determining Medicaid eligibility.

PSC 763

Resources and in-kind support factors should be reviewed, since they are not considered in the NJ FamilyCare eligibility for this group, but are counted when determining Medicaid eligibility.

Face-to-face Requirement

Waived for the ex parte review.
Mail in or face-to-face for redetermination

Eligibility Date:

New Jersey Care eligibility date will be effective retroactive to the initial NJ FamilyCare date, but no earlier than 9/1/00.

Notices:

If Medicaid eligible for New Jersey Care, notice advising beneficiary of eligibility dates and Medicaid HSP# will be issued and change in their services, if applicable.
If ineligible, a denial notice is not necessary, but a case dismissal notice should be included in the record to show case disposition.

Coordination:

Coordinate the eligibility segments with the supervising agency in order to assure that there is no lapse in coverage, per current practice.

County Boards of Social Services

For each approved disability case, the DRT forwards the DMAHS cover letter, a copy of the DRS-3/PA-8 form, medical documentation and turnaround document to the CWA New Jersey Care liaison for a financial eligibility determination.

I. Eligibility Processing

A. Work First New Jersey/General Assistance cases (PSC 761)

1. CWA Cases (County of Supervision 1-21)

   a. New Jersey Care liaison obtains a copy of the current WFNJ/GA application and case materials to create a New Jersey Care record and to determine Medicaid eligibility, using other available case information (ex parte);

   b. Since we are allowing for a concurrent disability determination, if there is evidence in the WFNJ record that the individual has applied for SSI and is awaiting a decision, this fact should be noted in the case record for later follow-up;

   c. Medicaid eligibility is determined effective to the initial NJ FamilyCare eligibility periods, but no sooner than 9/1/00.

   Upon an eligibility determination, the county agency is responsible for the following.

   a. **Medicaid Approval:**

      i. The county agency advises the beneficiary of his or her New Jersey Care eligibility using the appropriate notice;

      ii. The county agency advises DMAHS and its WFNJ agency liaison of eligibility by forwarding a copy of the turnaround document with the Medicaid eligibility information;

      iii. The county agency accretes the New Jersey Care eligibility data to the MEF card appropriate and coordinates the addition of Medicaid eligibility data on the GAAS as applicable for the WFNJ beneficiary, in order that duplicate eligibility does not exist and two cards are not produced, according to current practice;

      iv. The county agency redetermines eligibility for New Jersey Care on a 12-month basis, according to current Medicaid program rules for the disabled population. The date of the New Jersey Care eligibility determination defines the redetermination date.

b. **Medicaid Denial**

i. The county New Jersey Care liaison advises DMAHS and the WFNJ agency liaison of its denial determination by use of the turnaround document. No other action is required.

ii. No denial letter is sent to the beneficiary. A case dismissal notice is included in the case record.

2. MWD cases (099 county of supervision)

a. New Jersey Care liaison requests a copy of the current WFNJ/GA application and case materials from the supervising agency to create a New Jersey Care record and to determine Medicaid eligibility ex parte.

b. Since we are allowing for a concurrent disability determination, if there is evidence in the WFNJ record that the individual has applied for SSI and is awaiting a decision, this fact should be noted in the case record for later follow-up.

c. Eligibility will be determined effective for the NJ FamilyCare eligibility periods, but no sooner than 9/1/00.

Upon an eligibility determination, the county agency will be responsible for the following.

a. Medicaid Approval:

i. The county agency advises the beneficiary of his or her eligibility using the appropriate notice;

ii. The county agency advises DMAHS and its WFNJ liaison of the decision by forwarding a copy of the turnaround document with the eligibility information;

iii. The county agency accretes the New Jersey Care eligibility data to the MEF card appropriate and coordinates the addition of Medicaid eligibility on the GAAS, as applicable for the WFNJ beneficiary, in order that duplicate eligibility does not exist and two cards are not produced, according to current practice;

iv. The county agency redetermines eligibility for New Jersey Care on a 12-month basis, according to current Medicaid program rules for the disabled population. The date of the New Jersey Care eligibility determination defines the redetermination date.

b. **Medicaid Denial**

i. The county New Jersey Care liaison advises DMAHS and the WFNJ agency liaison of its denial determination by use of the turnaround document. No other action is required;

ii. No denial letter is sent to the beneficiary. A case dismissal notice is included in the case record.

B. NJ FamilyCare (PSC 762 and 762 or other NJ FamilyCare segments)

1. New Jersey Care liaison obtains a copy of the current NJ FamilyCare application and case materials to create a New Jersey Care record and to determine Medicaid eligibility;

a. Since we are allowing for a concurrent disability determination, if there is evidence in the NJ FamilyCare record that the individual has applied for SSI and is awaiting a decision, this fact should be noted in the case record for later follow-up;

b. Medicaid eligibility is determined effective to the initial NJ FamilyCare eligibility periods, but no sooner than 9/1/00.

2. Upon an eligibility determination, the county agency will be responsible for the following.

a. Medicaid Approval:

i. The county agency advises the beneficiary of his or her eligibility using the appropriate notice;

ii. The county agency advises DMAHS and its NJ FamilyCare liaison of the decision by forwarding a copy of the turnaround document with the eligibility information;

iii. The county agency accretes the New Jersey Care eligibility data to the MEF card appropriate and coordinates the addition of Medicaid eligibility on the Medicaid Eligibility File, for the NJ FamilyCare beneficiary, in order that duplicate eligibility does not exist and two cards are not produced, according to current practice;

iv. The county agency redetermines eligibility for New Jersey Care on a 12-month basis, according to current Medicaid program rules for the disabled population. The date of the New Jersey Care eligibility determination defines the redetermination date.

b. **Medicaid Denial**

i. The county New Jersey Care liaison advises DMAHS and the NJ FamilyCare agency liaison of its denial determination by use of the turnaround document. No other action is required;

ii. No denial letter is sent to the beneficiary. A case dismissal notice is included in the case record.